

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Gilbert		Middle CHASE		Last CHASE		2a. DATE OF DEATH Month Day Year Dec. 30 1967		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH Dec. 28, 1967			6. AGE (In years last birthday) YRS. MONTHS DAYS 2		2b. HOUR M		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CHARLES			Md.		
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Mem. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Infant			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Charles		13c. CITY OR TOWN Bel Alton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last Joseph Chase			15. MOTHER'S MAIDEN NAME First Middle Last Eleanor Hawkins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Joseph Chase, Bel Alton, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> 7625 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity 1#120g</u> DUE TO, OR AS A CONSEQUENCE OF (c)										12-30-67 12-28-67	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>E. J. Edelen</u>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-31-67			
22d. PHYSICIAN'S NAME (Type) E. J. EDELEN, M.D.				22e. ADDRESS La Plata, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 1, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius			23d. LOCATION (City or Town) (County) (State) Chapel Point, Charles, Md.				
24. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home Inc, La Plata, Md.				25a. RECD BY REGISTRAR DATE JAN 10 1968		25b. REGISTRAR'S SIGNATURE <u>John L. Jones</u>					

13. 10. 2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First ALICE			Middle CECELIA			Last COLE			2a. DATE OF DEATH Month Day 27, 1967			2b. HOUR M		
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH October 10, 1915			6. AGE (in years last birthday) 52 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Charles								
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Physicians Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Farming								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Charles			13c. CITY OR TOWN Wicomico			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER (Rural)					
14. FATHER'S NAME First Middle Last Jack Campbell			15. MOTHER'S MAIDEN NAME First Middle Last Estelle (Unkown)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No						16b. SOCIAL SECURITY NO. None			17. INFORMANT Address Dora Aliene Thomas -Chaptico, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> 5870 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic glomerulonephritis - Hypertensive Cerebrovascular Disease</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>12-26-67</u> , 19 <u>67</u> , to <u>12-27-67</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>12-27-67</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>J. Parran Jarboe M.D.</u>			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-29-67								
22d. PHYSICIAN'S NAME (Type) J. PARRAN JARBOE M.D.			22e. ADDRESS LA PLATA, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/30/1967			23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City or Town) (County) (State) Newport, Maryland								
24. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home, Inc.-La Plata, Md.			25a. REC'D BY REGISTRAR DATE JAN 3 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

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2. The second part of the document is a list of items.

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>C</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Charlotte Hall, Md</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>LEROY</b> Last <b>COLE</b>		4. DATE OF DEATH Month <b>12</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-3-58</b>
9. AGE (In years lost birthday) yts. <b>9</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>CHARLES, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>FRANK PERRY Dylon</b>		14. MOTHER'S MAIDEN NAME <b>ALICE COLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mother</b>		Address <b>CHARLOTTE HALL, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-18</b> , 19 <b>67</b> , to <b>12-21</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-18</b> , 19 <b>67</b> , and that death occurred at <b>6A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>F.M. Johnson</b>		22b. DATE SIGNED <b>12-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. JOHNSON M.D.</b>		22d. ADDRESS <b>LA PLATA, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>12/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chuech Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Charles County</b>
24. FUNERAL DIRECTOR <b>Leroy E. Berry</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 16 1968</b>	

From First Date

From First Date

From First Date



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16871

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16864

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. LENGTH OF STAY IN lb <u>WHITE PLAINS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PHYSICIANS MEMORIAL Hosp.</u>		d. STREET ADDRESS <u>08-1</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK EDWARD CONNELL</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TOBACCO</u>	9. AGE (In years last birthday) yrs. <u>79</u>
11. BIRTHPLACE (State or foreign country) <u>COLORADO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM E. CONNELL</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES GIRARDOT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-07-1097</u>	
17. INFORMANT <u>ROSE CONNELL, WHITE PLAINS, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gun shot</u> DUE TO (c) <u>Ice</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-18-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>12</u> a.m. <u>12</u> p.m. <u>12</u> 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>White Plains</u> (County) <u>Charles</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. Edele</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-21-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NAT. CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND P.G., MD.</u>	
24. FUNERAL DIRECTOR <u>HUNTT FUNERAL HOME, WILDFORD, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. DATE SIGNED <u>12-18-67</u>	

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VR A15  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16872

16865

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHITE PLAINS, MD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHYSICIANS MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM Gwynn Davis</b>		First Middle Last		4. DATE OF DEATH <b>12 19 1967</b>		Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-26-1882</b>		9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 year IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CHARLES, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GWYNN DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-16-4810</b>		17. INFORMANT <b>Otis Davis</b>		Address <b>White Plains, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sen Ant Joe</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>11-27-1967</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-17-67</b> to <b>12-19-67</b> , that (I) (we) last saw the deceased alive on <b>12-19-67</b> , and that death occurred at <b>12-19-67</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>E. J. Edeleu</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>E. J. EDELEU</b>				22d. ADDRESS <b>LA PLATA, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-22-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		23d. LOCATION (City, town or county) (State) <b>Waldore Chas. Md.</b>	
24. FUNERAL DIRECTOR <b>HUNTT FUNERAL HOME</b>				ADDRESS <b>Waldore, Md</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>			

Page 4

1905

CHURCHMAN



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17906

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> 12-22 19 67		2b HOUR M
JOHN BERNARD DAY (PRESUMPTIVE IDENTIFICATION)							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 12 Day 22 Year 19 67	2d HOUR 8 A M
Male	Negro	4/15/49	18 YRS				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH CHARLES Md			
MARBURY	MARYLAND						
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Indian Head							
13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER			
INDIAN HEAD	CHARLES	MARYLAND	YES <input type="checkbox"/> NO <input type="checkbox"/>				
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last
John			Edward DAY	Lena MARY			Queen
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO.		17 INFORMANT	ADDRESS			
NO			Lena M. Queen	EAST HOPPER LANE INDIAN HEAD MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extensive thermal burns							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 4:17 PM APR 12-22 19 67		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				Found just outside door of burned house			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town	County	State
	House		Displaced vacant house, Rte. 210		Indian Head	CHARLES	Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ADDRESS (Street, city, town, or county)		March 8, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL	3-25-68	St. Joseph's		Pomonkey Charles Md			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Mc Crimmon Funeral Home		Pomonkey, Md		MAR 22 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

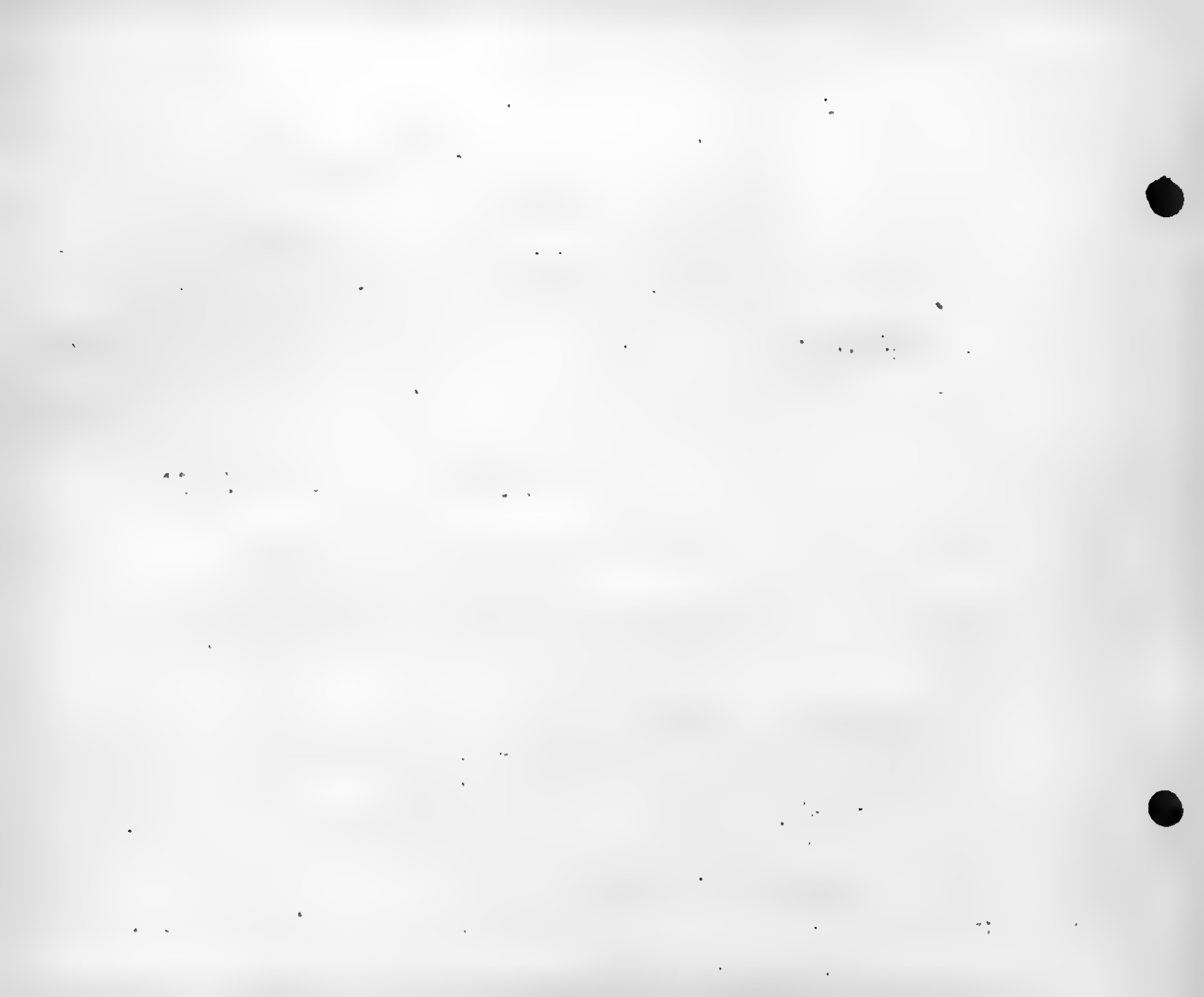
CERTIFICATE OF DEATH

16873

16866

1 DECEASED-NAME (Type or print) <i>Sidney H. Diman</i>			2a. DATE OF DEATH Month <i>Dec</i> Day <i>19</i> Year <i>67</i>			2b. HOUR <i>4:30 PM</i>				
3. SEX <i>M</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>7/27/90</i>		6. AGE (in years last birthday) <i>77</i> YRS.		F UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Charles</i> Md				
10. CITY OR TOWN OF DEATH <i>La. Plata</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Physicians Memorial Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) <i>Maryland</i>			13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>Cabin Island</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <i>FRANK</i> Middle <i>L.</i> Last <i>DIMAN</i>			15. MOTHER'S MAIDEN NAME First <i>GEORGINA</i> Middle <i>HOMER</i> Last <i>DEL CARRE</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO <i>577-10-124</i>		17. INFORMANT <i>Wm. Barnett</i>			Address <i>Annapolis, Md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>influenza</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic carcinoma to the lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>?</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <i>451X</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>12-19</i> , 1967, to <i>12-19</i> , 1967, that (I) (we) last saw the deceased alive on <i>12-17</i> , 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>F.M. Johnson</i>			DEGREE <i>M.D.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>12-21-67</i>	
22d. PHYSICIAN'S NAME (Type) <i>F.M. JOHNSON</i>			22e. ADDRESS <i>LA PLATA, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>			23b. DATE <i>12-22-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee Chapel</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington D.C.</i>		
24. FUNERAL DIRECTOR <i>Hardesty Funeral Home</i>			ADDRESS <i>Annapolis, Md</i>			25a. REC'D BY REGISTRAR DATE <i>JAN 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		

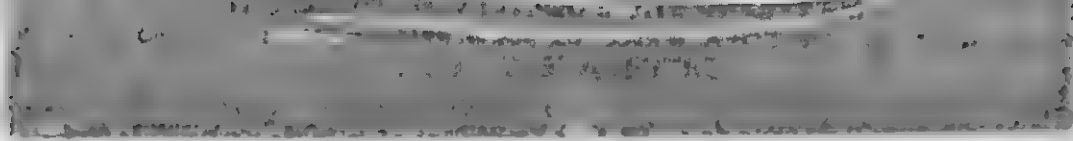
MEDICAL CERTIFICATION





TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>CERTIFICATE OF DEATH</b>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Physicians Memorial Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> d. STREET ADDRESS <u>Oak Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>WILLIAM AUGUSTUS FOWKE</u>					<b>4. DATE OF DEATH</b> Month Day Year <u>December 3, 1967</u>						
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 4, 1892</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Resident Engineer-Ret. State Roads</u>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>William A. Fowke</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Jane F. Stonestreet</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes 1916</u>					<b>16. SOCIAL SECURITY NO</b> <u>Unknown</u>					<b>17. INFORMANT</b> Address <u>Agnes Fowke -Wife -La Plata, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO <u>Cerebral Vascular Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mediastinal Tumor</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>12-9-67</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-9-67</u> <b>to</b> <u>12-3-67</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12-2-67</u> <b>and that death occurred at</b> <u>11-9-67</u> <b>from the causes and on the date stated above</b>			
<b>22a. SIGNATURE</b> <u>E.J. Edelen</u>					<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12/3/1967</u>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>E.J. Edelen, M.D.</u>					<b>22d. ADDRESS</b> <u>La Plata, Md.</u>						
<b>23a. BURIAL, CREMATION, or other disposition</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/5/1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Rest Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>La Plata, Maryland</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arehart Funeral Home, Inc.-La Plata, Md.</u>					<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10868

FOR STATE  
HEALTH DEPT.

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Nd</u> b. COUNTY <u>Chas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayfield Nd</u>	
c. LENGTH OF STAY in 1b <u>Life</u>		d. STREET ADDRESS <u>1224-09</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>THOMAS HILARY GRAY</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-09</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Government Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nd</u>	
11 BIRTHPLACE (State or foreign country) <u>Nd</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Gray</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Washington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-18-8009</u>	
17. INFORMATION <u>Gray, father Nd</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>12-24-67</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>12-24-67</u> (b) <u>12-24-67</u> (c) <u>12-24-67</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-24-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Fodell</u> M.D.		22. DATE SIGNED <u>12-24-67</u>	
EXAMINER'S NAME (Type) <u>F. J. FODELL</u>		Address (Street, city, town, or county) <u>Indian Head Charles Nd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>Indian Head Charles Nd</u>
24. FUNERAL DIRECTOR <u>Leroy E. Berry-Huntingtown Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>DEC 27 1967</u>	



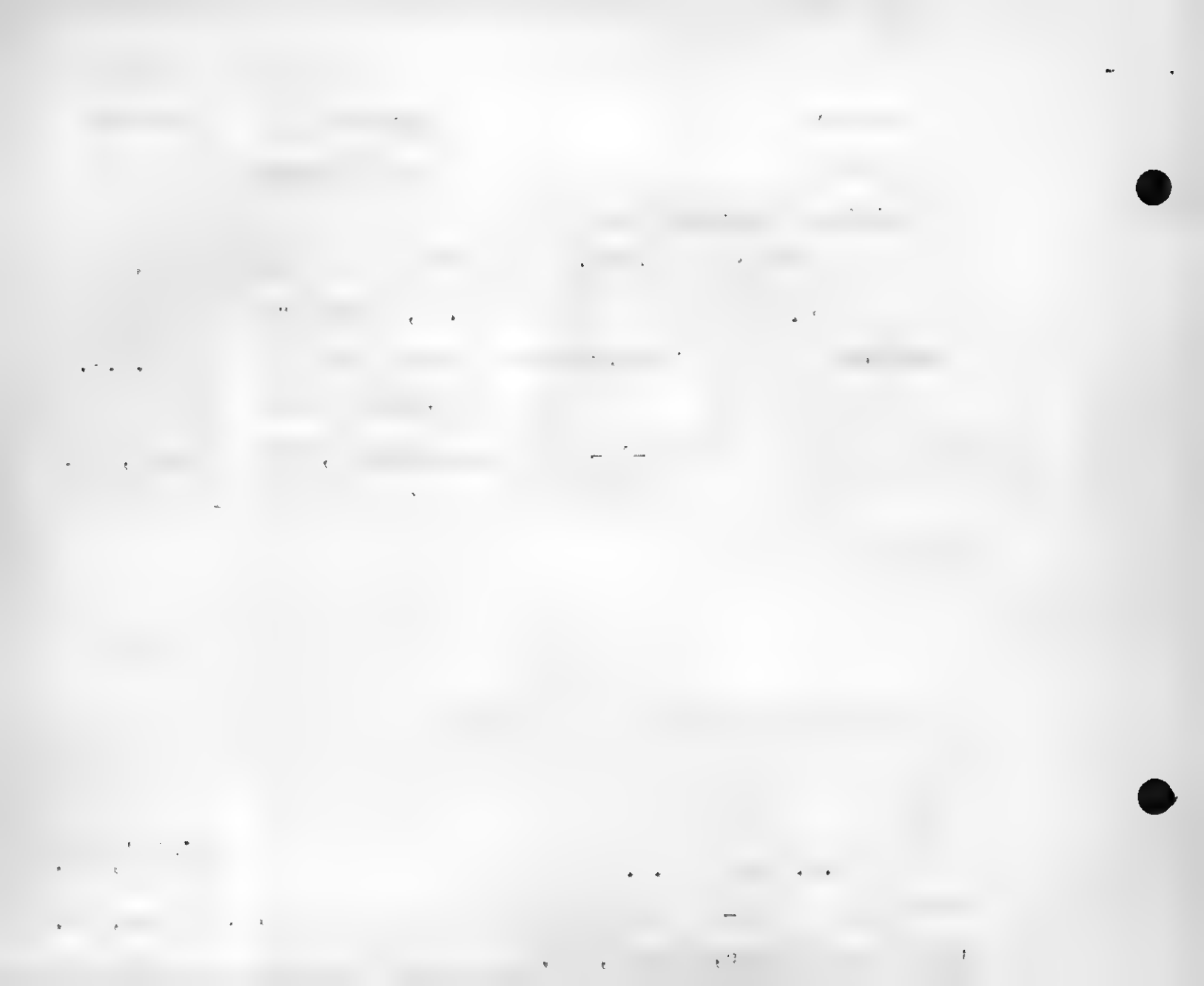
FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Plains</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Edward</b> Last <b>Hamilton</b>						4. DATE OF DEATH <b>December 16, 1967</b> Month <b>December</b> Day <b>16</b> Year <b>1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 14, 1914</b>		9. AGE (In years lost birthday) <b>53</b> yrs		IF UNDER 1 YEAR F UNDER 24 HRS Months <b>12</b> Days <b>26</b> Hours <b>07</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roy Hamilton</b>						14. MOTHER'S MAIDEN NAME <b>Amanda Pickeral</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO <b>212-14-5036</b>		17. INFORMANT <b>Roy Hamilton, White Plains, Md.</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) <b>Interval between onset and death 12/16/67</b>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>E.J. Edelen</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <b>Dec. 16, 1967</b>			
EXAMINER'S NAME (Type) <b>E.J. Edelen M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12-18-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City or Town, County, State) <b>Waldorf, Charles, Md.</b>			
24. FUNERAL DIRECTOR <b>Huntt Funeral Home, Waldorf, Md.</b>						25a. DECEASED BY <b>DEC 21 1967</b>		25c. DECEASED'S SIGNATURE <b>Charles Judge</b>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <b>LYDIA</b> First Middle Last <b>HOLMES</b>		4 DATE OF DEATH Month <b>12</b> Day <b>15</b> Year <b>1967</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5-24-90</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) yrs <b>77</b>
11 BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Wm. S. Steinacker</b>		14 MOTHER'S MAIDEN NAME <b>Elizabeth Heisler</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	17 INFORMANT <b>Wm. J. Holmes</b> Address <b>1209 N.W. 11th Terrace, Ft. Lauderdale, Fla.</b>
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>4:00 PM</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>12-15-67</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Street</b>	20f. CITY OR TOWN <b>La Plata Charles</b> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E.J. Edelen</b> M.D.		22. DATE SIGNED <b>12-15-67</b>	
EXAMINER'S NAME (Type) <b>E.J. Edelen, M.D. La Plata, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>
24. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Av.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay's necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Rock Point</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physician's Memorial Hospital</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Charles Elizha Hudson Jr.</u>						4 DATE OF DEATH <u>12</u> Month <u>3</u> Day <u>67</u> Year					
5 SEX <u>Male</u>		6 COLOR OR RACE <u>Negro</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH <u>1931</u> Dec. <u>25</u> , <u>1931</u>		9 AGE (In years last birthday) <u>35</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>New Jersey</u>				12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 DECEASED'S NAME <u>CHARLES Hudson</u>						14 MOTHER'S M maiden NAME <u>Josephine Campbell</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>263-40-1772</u>		17 INFORMANT <u>Ida Mae Thomas, Rock Point, Md.</u> Address					
18 CAUSE OF DEATH (Enter only one cause per line (a), (b) and (c))											
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Multiple crushing</u>											
DUE TO (b) <u>injuries to chest</u>											
DUE TO (c) <u>fire &amp; gas envelope</u>											
19 INTERVAL BETWEEN ONSET AND DEATH <u>12-3-67</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Head on auto accident (Driver)</u>											
20c. TIME OF INJURY Month, Day, Year <u>4:30 P.M. 12-3-67</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off a bldg, etc.) <u>Highway</u>		20f. (City or town) <u>Highway, Charles Md</u> (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E.J. Edelen</u> M.D.						22. DATE SIGNED <u>12-3-67</u>					
EXAMINER'S NAME (Type) <u>E.J. Edelen, La Plata, Md.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL (CREMATION REMOVAL) (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec. 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Methodist</u>				23d. LOCATION (City or town) (County) (State) <u>Newburg, Charles, Md.</u>	
24 FUNERAL DIRECTOR <u>Berry Funeral Home, Pomonkey, Md.</u> ADDRESS						25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16873

CERTIFICATE OF DEATH

16872

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>NEW HAMPSHIRE</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN TB <b>5 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ossipee</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHYSICIANS MEMORIAL HOSPITAL</b>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <b>ROUTA S. LIVINGSTON</b>		4 DATE OF DEATH Month <b>DEC</b> Day <b>14</b> Year <b>1967</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-1-1890</b>
9. AGE (In years last birthday) <b>77</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>New Hampshire</b>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edwin Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>--</b>	
17 INFORMANT <b>Mrs. James McCallum</b>		Address <b>321 Avenue C., New York City</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Collapse</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Cerebral vascular accident</b> DUE TO (c) <b>Hypertensive Cardio vascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9 Dec</b> , 19 <b>67</b> , to <b>14 Dec</b> , 19 <b>67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>14 Dec</b> , 19 <b>67</b> , and that death occurred at <b>12:15 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur P. Woody, MD</b>		22b. DATE SIGNED <b>14 Dec 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR P. WOODY, MD</b>		22d. ADDRESS <b>LA PLATA, MARYLAND 20646</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>Dec. 15, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
100000  
10873  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>CHARLES</u> b. COUNTY <u>MARYLAND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>INDIAN HEAD, MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>LA PLATA, MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PHYSICIAN MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>Estella</u> Middle <u>Matthews</u> Last		4. DATE OF DEATH <u>12</u> - <u>11</u> - <u>1967</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/4/1904</u>		9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>11</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Matthews</u>				14. MOTHER'S MAIDEN NAME <u>MARY Shelton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>100-100000</u>		17. INFORMANT <u>Agnes Smith</u> Address <u>Rising, MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C. U. A.</u> <u>221X</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Yell. Cerebral Infarction</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> , 19 <u>67</u> to <u>12/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>67</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Arturo M. Monteiro</u>				22b. DATE SIGNED <u>12/14/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Arturo M. Monteiro</u>	
22d. ADDRESS <u>LA PLATA, MD</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)					
23b. DATE THEREOF <u>12-15-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent's</u>		23d. LOCATION (City, town or county) (State) <u>Indian Head, MD</u>			
24. FUNERAL DIRECTOR <u>Beaumont Funeral Home</u>		ADDRESS <u>Indian Head, MD</u>		25a. REC'D BY REGISTRAR <u>DEC 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

15874

1 PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b> c. LENGTH OF STAY IN b <b>15</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bryans Road</b> d. STREET ADDRESS <b>CR 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>PAUL</b> First Middle Last <b>PAUL RIEDEL</b>		4. DATE OF DEATH Month Day Year <b>Dec 22 1967</b>	
5 SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-11-1900</b>
9. AGE (In years last birthday) yrs <b>67</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTO PARTS</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LOUIS RIEDEL</b>	
14. MOTHER'S MAIDEN NAME <b>UNK</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>233-03-4541</b>		17. INFORMANT <b>HATTIE RIEDEL, Bryans Rd., MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary artery disease</b> DUE TO <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>INFLUENZA.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>18 Dec 1967</b> to <b>22 Dec 1967</b> (that I) (we) last saw the deceased alive on <b>22 Dec 1967</b> , and that death occurred at <b>8:50</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur O. Woody</b>		22b. DATE SIGNED <b>23 Dec 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY, MD</b>		22d. ADDRESS <b>LAPLATA, MARYLAND - 20645</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-27-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEM. GARDENS</b>	23d. LOCATION (City or Town) (County) (State) <b>WALDORF, CHARLES, MD.</b>
24. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME, WALDORF, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 28 1967</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

16882

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16882

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>NEW YORK</b> COUNTY <b>NEW YORK</b>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. LENGTH OF STAY IN 1b <b>P.D.A.</b>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>NEW YORK, N.Y.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHY. MEM. HOSPITAL</b>				d. STREET ADDRESS <b>7 W. 81 ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SAMUEL</b> First <b>RODMAN</b> Middle Last				4. DATE OF DEATH Month <b>12</b> Day <b>10</b> Year <b>1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 15 1898</b>		9. AGE (In years lost, birthday) <b>69</b> yrs	10. F UNDER 1 YEAR 1 DAY 1 HOUR 1 MIN	
10a. USUA. OCCUPAT OR (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BENJAMIN RODMAN</b>				14. MOTHER'S MAIDEN NAME <b>SARAH HERSHMAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MORRIS RODMAN 705-18 St., N.W. Washington DC</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Coronary Occlusion</b> (b) <b>12-10-67</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. J. EDELEN</b> M.D.				22. DATE SIGNED <b>12-10-67</b>			
EXAMINER'S NAME (Type) <b>E. J. EDELEN, LAPLATA, MD</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>		23b. DATE THEREOF <b>12-11-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lees Crematory</b>		23d. LOCATION (City or town) (County) (State) <b>Washington DC</b>	
24. FUNERAL DIRECTOR <b>Reichart Funeral Home of Laplata</b>				25. REC'D BY REG-STRAR <b>DEC 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16882

15876

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crown Pt</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crown Pt</u>		d. STREET ADDRESS <u>Med</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRWIN</u> First <u>E</u> Middle <u>RODABUSH</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4 1899</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST RET</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>ELKTON VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM D. RODABUSH</u>		14. MOTHER'S MAIDEN NAME <u>DORA CUTSHALL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>X18-155-031A</u>	
17. INFORMANT <u>MAGGIE RODABUSH</u> Address <u>6066 ISLAND MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-3-67</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Hypertension and Ben-art Acc</u>		(b) <u></u>	
(c) <u></u>		(d) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>12-8</u> , 19 <u>67</u> , to <u>12-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-8</u> , 19 <u>67</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>E. J. EDELED</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E. J. EDELED</u>		22d. ADDRESS <u>LA PLATA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-12-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Switzman P.D. Md</u>	
24. FUNERAL DIRECTOR <u>Berkant Funeral Home and Chapel</u> ADDRESS		25a. REC'D BY REGISTRAR <u>Charles J. Jones</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>DEC 15 1967</u>	



## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dentsville (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicans Memorial Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>JAMES EDGAR STONE STREET</b>		4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1902</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>25</b> Hours <b>19</b> Min <b>67</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Gallent Green, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas Stonestreet</b>		14. MOTHER'S MAIDEN NAME <b>Annie Klimkiewicz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-22-8030</b>	
17. INFORMANT <b>Dentsville, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Influenza</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>(with failure)</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		20. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>67</b> to <b>Dec</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-25-1967</b> , and that death occurred at <b>11 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>F.M. Johnson</b>		22b. DATE SIGNED <b>12-25-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. JOHNSON MD</b>		22d. ADDRESS <b>La Plata Md</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/28/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Newport, Maryland</b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc.-La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and direct, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

16878

1 PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>18-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>		e. STREET ADDRESS <b>La Plata</b>	
3 NAME OF DECEASED (Type or print) First <b>VIOLA</b> Middle <b>May</b> Last <b>SWANN</b>		4 DATE OF DEATH Month <b>12</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1911</b>
9. AGE (In years last birthday) <b>56</b> yrs		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>21</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>File Searcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Charles County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>E. Leigh Edelen</b>		14. MOTHER'S MAIDEN NAME <b>Marguerite Willett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-22-0182</b>	
17. INFORMANT <b>Mrs. Betty Johnson-Daughter</b>		Address <b>La Plata, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CIRRHOSIS OF THE LIVER</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCT</b> , 1967, to <b>DEC</b> , 1967, that (I) (we) last saw the deceased alive on <b>12-21</b> , 1967, and that death occurred at <b>6:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>12-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. M. JOHNSON MD</b>		22d. ADDRESS <b>LA PLATA, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/23/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Pomfret, Maryland</b>
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16886

16879

1 PLACE OF DEATH a COUNTY <b>Charles</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>		a STREET ADDRESS <b>Smith Point Road</b>	
3 NAME OF DECEASED (Type or print) <b>ROBERT L. WAGNER</b>		4 DATE OF DEATH Month <b>12</b> Day <b>2</b> Year <b>1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-13-09</b> AGE (In years and birthday) <b>28</b> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver - Retired</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John H. Wagner</b>		14 MOTHER'S MAIDEN NAME <b>Daisey Lister</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>Unknown</b>	
17 INFORMANT <b>Mrs. Dorothy Wagner-Wife-Nanjemoy, Md</b>		Box 128 Route # 1	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chloroform Accidents</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Asphyxiation and</b> DUE TO (c) <b>Red ant bedsores</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E.J. Edelen</b> MD		22. DATE SIGNED <b>12-2-67</b>	
EXAMINER'S NAME (Type) <b>E.J. Edelen, M. D. La Plata, Md.</b>		22. DATE SIGNED <b>12-2-67</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>12/5/1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Cemetery</b>	23d LOCATION (City or town) (County) (State) <b>Hill Top, Maryland</b>
24 FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>		25a REC'D BY REGISTRAR <b>DEC 7 1967</b>	25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Item 20 Film 396 12-18-67 MARYLAND STATE DEPARTMENT OF HEALTH  
12-18-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hill Crest Hights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LaPlata Memo. Hospital</b>		d. STREET ADDRESS <b>2418 Iverson St.</b>	
3. NAME OF DECEASED (Type of print) <b>Lillian</b> First <b>William</b> Last <b>Williams</b>		4. DATE OF DEATH <b>12-2-67</b> Month <b>12</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-6-1910</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Knott</b>		14. MOTHER'S MAIDEN NAME <b>Ida R. Barber</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John Simms</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>816.4</b> IMMEDIATE CAUSE (a) <b>Acute Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Cerebral Aneurysm</b> (c) <b>Chronic Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12-2-67</b> <b>12-3-67</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car - head on rear collision</b>	
20c. TIME OF INJURY Month, Day, Year <b>4:30 p.m. 12 3 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wayside</b>		20f. (City or town) (County) (State) <b>Charles Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>12/3/67</b>	
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>[Signature]</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-7-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>	
ADDRESS <b>Washington, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

Two for 1 certificate Film #G397 1/25/68 ph

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomfret</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomfret</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>RURAL</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Hoffman Winkler</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>25</u> - Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1898</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months <u>08</u> Days <u>06</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pomfret, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Winkler</u>		14. MOTHER'S MAIDEN NAME <u>Emily Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-38-7711</u>	
17. INFORMANT <u>Helen G. Winkler, Pomfret (Md.)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Infarction</u> 4201 DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>See above</u> DUE TO (c) <u>See above</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-24-67</u> to <u>12-25-67</u> , that (I) (we) last saw the deceased alive on <u>12-24-67</u> , and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Edelen</u>		22b. DATE SIGNED <u>12-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Edelen MD</u>		22d. ADDRESS <u>La Plata, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Chas. Md.</u>
24. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Waldorf, Md</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 29 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

